Gender Differences, Reproductive Health and Decision-Making

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Introduction

Decision-making is defined as making a choice from two or more alternatives (Robbins & Coulter, 2002). This simple definition does not do justice to the complex nature of the process of decision-making. Some decisions appear to be made in a very short period of time as in intuitive decision-making, whilst others appear to be more deliberate and structured as in analytical decision-making. Though intuitive decisions appear to be made in seconds, it is actually “a highly complex and highly developed form of reasoning that is based on years of experience and learning, and on facts, patterns, concepts, procedures and abstractions stored in one’s head” (Matzler, Bailom, & Mooradian, 2007, p. 12). Hence, however simple a decision may appear, it actually involves a complex process which is cognitively reasoned.

Making decisions in health are difficult due to the different situations that need different types of decision. An individual’s mode of decision-making varies depending on the context the decision is to be made. Bekker et al. (1999) provided six different conditions which affect a person’s ability to make decisions: the type of decision to be made (treatment, healthy lifestyle, preventive care); seriousness of the outcome (between taking a medication for pain and donating an organ); familiarity with the decision; level of certainty of the outcome of a decision; the health domain; and the recipient of the decision, either for own self or for others under a person’s care.

In addition, decisions are usually made in the context of their social environment and cultural constraints. Having the information to make a decision raises other challenges to an individual who then needs to decide which outcome is preferred. A desired outcome is explicit to an individual. What is desired by one individual may not be the same for others. It
depends on the values and perceptions of the individual self (Paterick, Carson, Allen, & Paterick, 2008). For health providers for example, a decision on a treatment is based solely on medical evidence and experience, and centred on reducing morbidity or at least mortality. However, for an individual, considerations on treatment options do not only take into account the outcome of treatment on one self, but also on their effects on family, career, roles and responsibilities.

**Gender differences in decision-making**

Women and men make decisions differently. Women take a longer time to make a decision as they are affected by the situation they are in. Hence, they look for more information compared to men. They consider the consequences of their decision not only on themselves but also on the people who will be affected by their decision. They are also influenced by their emotions. Whereas, men’s dominant character makes them more realistic and assertive in their decision-making. Their decisions are more purposive in achieving the goals (Sanz de Acedo Lizarraga, Sanz de Acedo Baquedano, & Cardelle-Elawar, 2007). Nonetheless, women who pursue higher education in traditionally ‘masculine’ courses such as business, was found to demonstrate male-orientated ways of opinion and judgement (Crow, Fok, Hartman, & Payne, 1991).

Some studies have shown that gender intersects with poverty and income level in the dynamics of decision-making power. Women in rural areas for instance, do not have the autonomy to household decisions such as health care, household purchase and visits to relatives (Acharya, Bell, Simkhada, Tejlingen, & Regmi, 2010). Furthermore, in rural communities, men are expected to be leaders in household as well as the community, whilst women are the supporters (Opare, 2005).

Men and women are involved in different decisions differently. A study in Pakistan for instance, found that most of the women were involved in decisions concerning reproductive health such as family planning, personal decisions such as clothing expenditures and domestic decisions such as food and medical concerns. However, decisions on matters pertaining to education and employment were mostly decided solely by men (Hou & Ma, 2011).

**Decision-making in reproductive health in the context of gender differences**

Making a decision in matters pertaining to reproductive health involves the intimate relationship between partners. Decision on using condom for family planning or prevention of sexually transmitted infections for instance, requires both partners’ agreement as it involves the intimacy of their sexual relationship. Communication and consensual agreement of both partners are essential for a reproductive health care decision. A few studies have shown couples’ preference for shared decision-making. A study in Honduras for example, showed that the majority of women (54%) and men (63%) believed that decisions pertaining to family planning should be made by both partners (Speizer, Whittle, & Carter, 2005). Nevertheless, the same study found that there was an incongruity between preference and the actual practice whereby among some of the couples, men made the final decision rather than by both the partners. Similarly, when there is discordance in agreement between partners, it is
usually the male partner who makes the final decision. This is especially true in a patriarchal society in which men’s power over decisions dictates that the women must obey and that any objection is not acceptable. This imbalance of power in making decision deprived women from making their own decision concerning reproductive health. In a study in Tanzania for instance, men as the head of a household were the dominant decision makers and the women’s ability to practise family planning depended on their husbands’ approval (Schuler, Rottach, & Mukiri, 2011).

Therefore, the outcome of a decision depends on the men’s attitudes toward reproductive health issues, which in turn, depend on the norms of the society. For various reasons, men’s decisions and cultural norms in some societies had resulted in detrimental effects on women’s health. For example, in a study in South Africa by Strebel et al. (2006), violence against women was considered as portrayal of male dominance. As a result, women stayed in abusive relationships for years and would only report when they could not tolerate the beatings anymore. On the other hand, husbands were also the victims of abuse in the same society. Men usually refuse to report due to embarrassment.

In a society with patriarchal norms, the power to make decision is held by the husbands. Women’s decisions over their health and body are being controlled by men and consequently, this have an effect on the women’s life. Women are not only expected to obey but any protests or arguments might result in violence against the women (Schuler et al., 2011). Women in this society usually have no choice but to accept this practice. Men are the ones who decide. Hence, empowering women with knowledge on reproductive health matters might not be translated into the ability of the women to practise safe sexual behaviour or reproductive health care. Access to resources and to health care is being controlled by their husbands.

Unequal gender structure has been held responsible for the mortalities and morbidities that threaten women’s wellbeing. It denies women of their rights to make their own decisions and to exercise their health needs. Women’s exposure to human immunodeficiency virus (HIV) (Wingood & DiClemente, 2000) and other sexually transmitted diseases as a result of being coerced to have unprotected sex are some of the negative health outcomes which reflect women’s submissive position and lack of control over their own reproductive health (Amin & Bentley, 2002; Carovano, 1992).

Denial of women’s rights to make their own decision on reproductive health matters has been shown to affect not only on women’s individual health, but also on global population development. In many parts of the world, gender inequality impacts maternal outcome and children’s health. Hence, gender equality and women’s empowerment have received international attention. The 1994 International Conference on Population and Development (ICPD) Programme of Action in Cairo witnessed countries’ commitment to achieve universal access to sexual and reproductive health by 2015 (United Nations Population Fund [UNFPA], 2004a). The Plan of Action centres on human rights which include gender equality and women empowerment. The Programme of Action was later taken up and incorporated in the Millennium Declaration and Millennium Development Goals (MDG) in the year 2000 (UNFPA, 2004b). Several strategies were recommended to promote women’s empowerment. These include economic and political access, non-discriminating legislation, and assurance of gender equality at all levels of education attainment. These strategies were enacted to reduce the gender gap between men and women and were perceived to diminish the gender-related barriers. Subsequently, these would enable women to make their own decisions and experience better reproductive health outcomes.
As a result of the commitment made by many countries in the ICPD Programme of Action and other international declarations to ensure gender equality, more women have attained higher levels of education and are involved in paid employment, which subsequently, gives them access to their own personal income. These efforts have been shown to increase women’s power to make decisions in various reproductive health matters. A study in Nepal for instance, showed that women with higher educational level had higher participation rates in reproductive health decision (Chapagain, 2006). Other measures used in the study which were found to be associated with higher participation rates in reproductive decision include having a personal income, participation in political and social activities and having higher access to media. Hence, increasing women’s opportunities and access to education and paid employment had resulted in changing the women’s level of participation in reproductive decisions.

These changes in the society have also affected changes in the norms of women’s gender roles. Traditionally, men were the breadwinners and women’s domestic roles had prevented them from working outside their homes. However, gender equality movements as well as economic needs of the family have pushed women to work and contribute to the economy of the family. In societies where women are still expected to carry out their domestic roles, women carry the double burden of work, and this has affected women’s health (Payne & Doyal, 2010) and health behaviour (Artazcoz, Borrell, & Benach, 2001). Many of the women’s decisions to seek health care were impeded by this double burden of work. Hence, while providing women with the means to exercise their power, gender equality measures can also impede women’s health and their access to health care.

Nevertheless, in some patriarchal society, women have the bargaining power although the men are portrayed to be the ones making the final decision. Women who have bargaining power are able to voice their opinions on reproductive health matters. Although the husbands are the ones who finally decide, the women’s opinion and needs are taken into consideration. In addition, the current practices in patriarchal societies have revealed involvement of women in reproductive health decisions. Several studies in Nepal for instance, reported that joint decisions were made by couples on family planning usage (Chapagain, 2006; Mullany, Hindin, & Becker, 2005).

Women’s ability to make decision on reproductive health matters depends on the level of autonomy that they have. In a society where collective decision is being practiced, decisions are made by selected people or group of people in the society. Hence, not only the decisions regarding the women, but also the decisions concerning the couple are made by this group of people. Interestingly, in some societies, this group of people is women. In Pakistan for instance, reproductive health matters are decided by older women in the community (Mumtaz & Salway, 2009).

Studies which measure women’s empowerment used several different variables to reflect women’s level of power and factors which determine women’s empowerment. Self-report by women found that factors which influence women’s empowerment varied across societies. Women’s power depends on several factors. Gupta (1997), in her illustration on the prevention of HIV infection, identified five main elements. They are “information/education; economic resources; mobility/access; perceived social support; and supportive norms, policies, and laws” (Gupta, 1997, p. 60). These elements affect not only the hierarchical status of women, but also the women’s ability to bargain for their reproductive needs. Correspondingly, Chapagain’s (2006) study revealed that women with higher level of
education, personal income, access to media, and involved in social organisation had higher participation rate in decisions on contraception (between 80% and 92%). Conversely, women who had experienced domestic violence showed lower rate of participation in contraceptive decision (29%). Other variables which were found to be associated with women’s autonomy to make their own decision on health care were increasing age and number of children (Senarath & Gunawardena, 2009). A study in Nepal found that women’s autonomy to make decision concerning health care was related to sociodemographic profile such as age, income generating employment, and higher educational level (Acharya et al., 2010). There are times when women’s decision is not controlled by power relations alone, but by complex interactions of various gender issues.

Among couples in which the women have the autonomy to make decision, male partners were rarely consulted for opinion or information (Lindberg & Nolan, 2001). Similarly, their male partners did not actively seek to participate in the decision. The women’s sources of information were from close female friends or relatives. Women’s autonomous decision is affected by their gender roles and norms in the society. For example, the study by Lindberg and Nolan (2001) found that even when having decided to have hysterectomy done for a gynaecological problem, the female respondents managed to make arrangements regarding their roles and responsibilities. Besides getting support or help for some of their duties such as child care or work, the women arranged the surgery schedule to accommodate their family events such as waiting for their children to finish exams. Plans were also made to ensure that the period of recovery was during convenient times such as when their children are back at school. These were made in the midst of having serious symptoms such as profuse bleeding. The sense of duty of women is so strong that even when going for a major surgery, arrangements were made to avoid disruption of routines and roles.

Ironically, in the midst of efforts to increase women’s autonomy to make reproductive health decisions, interventions were created to involve men in reproductive health care (Mullany, 2006). Ignorance and the lack of knowledge on reproductive issues were seen as barriers to a healthy reproductive decision by men (Dudgeon & Inhorn, 2004). The perception that men need not know about reproductive matters has resulted in negative outcomes. For instance, men refuse to cooperate in family planning or prevent women from seeking reproductive health care (Schuler et al., 2011). Even in situations in which women have the autonomy to make decisions, the husbands’ involvement can motivate women towards a healthy reproductive health. A study in Ethiopia for instance, found that husbands’ involvement in family planning decision had a positive influence on the wives’ contraceptive use (Haile & Enqueselassie, 2006).

Conclusion

For researchers, investigating on who actually made decision and who had the power to make decision among couples can be difficult. This issue was pointed out by Becker, Fonseca-Becker, and Schenck-Yglesias (2006). The findings depend on who reports on and responds to the question(s). Is it the wife, or the husband? This matters because the respondents will respond according to what is expected of them in the society.

The final choice of a decision depends on the values and beliefs of the person who decides. In a patriarchal society, husbands are the decision makers on household matters as well as on
reproductive health issues. Their perceptions influence the decision that is to be made. Husbands’ perceptions portray the values of the society, and their interpretations of these values are subjective (Wambui, Ek, & Alehagen, 2009). The perception of manhood might be interpreted as having many children. Men would then decide to refuse the use of family planning (Schuler et al., 2011).

References


